## Michigan Department of Community Health Bureau of Health Systems Division of Nursing Home Monitoring

## CERTIFICATE OF APPOINTMENT FOR AUTHORIZED REPRESENTATIVE

Facility N	ame:			
Address:_		_City:	Zip:	
	hereby given to the Michigan Dep of Rules for Nursing Homes that	partment of Co	ommunity Health in accordance with a	
	_		has appointed	
,	facility requesting license and/or certificat	•		
(Name)		as its authorize	ed representative to:	
a.	Submit applications and make amendments thereto.			
b.	Provide the Department with all information necessary for a determination with respect to applications.			
c.	Enter into agreements with the Department in connection with licensure or certification.			
d.	Receive notice and service of process in matters relating to licensure or certification.			
This action taken on(Date)		and	and is effective immediately.	
	intment will remain in effect until of Nursing Home Monitoring.	written notice	e of termination is sent to the Director,	
Signature of Owner			Title	
Witness:		_	Date:	
Witness:		_	Date:	
Please ren	nit to:			
Bı Di P.(	epartment of Community Health ureau of Health Systems vision of Nursing Home Monitorin O. Box 30664 unsing, MI 48909	ng		

Authority: P.A. 368 of 1978 as amended Completion: Voluntary BHS-NHM-125 (Rev. 02/04) The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, martial status, disability, or political beliefs.